(cut and return the registration form only)

Basic Medicaid Seminars
Seminar Registration
(No Fee)

Provider Name _____ Provider Number _____
Address _____
City, Zip Code _____County_____
Contact Person _____ E-mail Address _____
Telephone Number (___)_____ Fax Number (___)_____

1 or **2** (circle one) person(s) will attend the seminar at _____on_____
(location) (date)

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622